Commentary

TRANSGENDER ANXIETY, CULTURAL ISSUES, AND CANNABIS IN OBSESSIVE-COMPULSIVE DISORDER

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Safer et al (1) report on the interesting case of a patient with severe, anxiety-producing doubts about his gender identity. He is described as a 20-year-old African American male with a sexual identity characterized by same-sex attraction. His obsessive-compulsive disorder (OCD) symptoms started abruptly after the use of marijuana, at which point he began to question his gender identity. Specifically, he suffered from obsessions of being transgender that caused him marked distress, engaged in functionally impairing mental and behavioral compulsions such as "testing" his reactions to certain thoughts or images and reassurance seeking. He also experienced suicidal ideation without active suicide plans or intent.

It may be interesting to consider possible reasons why the patient presented with this particular form of OCD at this time. OCD symptoms often focus on what is most salient to those afflicted, and sexual identity may be particularly salient in adolescents and young adults due to their developmental stage. Greater awareness of transgender issues due to greater representation in the media is likely to contribute to increased questioning and worry about gender dysphoria among young people prone to OCD. In addition, the role of cultural issues in this case must also be considered. There is greater stigma of lesbian, gay, bisexual, transgender, and queer identity within the African American community, and transgender African Americans are disproportionately likely to experience discrimination and violence from hate crimes than their transgender white counterparts (2). These social realities may have contributed to heightened anxiety and more obsessional worries in this particular patient.

Proper assessment of OCD is therefore vital, and even more so with the presentation of such understudied symptoms. OCD can be particularly challenging to diagnose by non–mental health professionals, especially when symptom presentations are unusual or have sexual themes. Furthermore, covert compulsions, which are common among those with sexual obsessions in OCD, are often missed by clinicians, which may result in a missed diagnosis or underestimate of symptom severity (3,4). This is why an assessment by an experienced mental health professional is essential if the patient exhibits doubts or anxiety about gender re-assignment surgery. For example, when assessing for transgender obsessions in a clinical interview, clinicians should determine if the unwanted thoughts about gender dysphoria (particularly about the possibility of gender re-assignment) are ego-dystonic. The second edition of the Yale-Brown Obsessive Compulsive Scale includes a question that asks specifically about gender identity, so this may be a good starting place (5).

Lastly, the onset of OCD symptoms after cannabis use has been reported in the relevant literature. For example, OCD symptoms have been linked to cannabis use in both case reports and epidemiologic studies (6-8). In our own clinical practice, we have observed the onset of new OCD symptoms in conjunction with a single use of cannabis in adolescents and young adults. Cannabis is known to predispose youth to motivational, affective, and psychotic disorders; there is strong evidence of the psychopathogenic effects of cannabis on the developing brain, and prospective longitudinal studies indicate that early cannabis use is associated with major depressive disorder and substance

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use disorders (9). In this case study, marijuana may have potentiated the patient's existing vulnerability to OCD – a vulnerability evidenced by prior subclinical symptoms and family history (i.e., brother with diagnosed contamination-based OCD). Thus, we strongly discourage cannabis use by young people with OCD or at risk for OCD. Nonetheless, further study of the relationship between cannabis and OCD is warranted.

DISCLOSURE

The authors have no multiplicity of interest to disclose.

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